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Abstract

This was a descriptive study designed to determine the relationship of functional impairment and self-concept of elderly clients with chronic illness. The null hypothesis stated that when the clients' scores on the Functional Assessment Form and Tennessee Self-Concept Scale were compared, there would be no significant correlation at the .05 significance level.

Data were collected from 15 subjects who were 65 years of age or over, had a chronic illness, and were receiving the services of a home health agency. All subjects were administered the Functional Assessment Form and the Tennessee Self-Concept Scale. These scores were then compared utilizing the Pearson Product Moment Correlation Coefficient at the .05 level of significance.

The results demonstrated significance between the subject's functional assessment score and one subscore, Column D, of the Tennessee Self-Concept Scale. Thus, the researcher rejected the null hypothesis.

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Chapter I

Problem Statement

The ability to function and maintain self-care in the elderly often deteriorates to the point of precipitating a dependency situation. Functional dependency is the decisive factor in an elderly person's capacity to remain at home and avoid family or institutional care (Ebersole & Hess, 1981). According to the Administration on Aging, 15.2% or 32.9 million of the resident population are over the age of 60. Statistics show that 86% of the aged experience chronic conditions, but 95% of these people are able to live in the community and 5% require institutionalization. Approximately 19% of those who live in the community require some type of assistance (Ebersole & Hess, 1981). Therefore, it is of great significance for the older person to be able to perform the tasks needed to remain at home, either independently or with assistance, in order to remain out of an institution. Such tasks might include the ability to complete personal care or perhaps self administer medications. When an older person can exhibit independence, it promotes and helps maintain positive self-concept, resulting in a feeling of being worthy and capable (Parent & Whall, 1984).

There are many reasons for the elderly to lose all or part of their independence. One reason for such a loss is a chronic illness, such as athritis, heart condition, cerebro-vascular accident with paralysis, diabetes, and lung disease. Chronic illnesses such as these often impair the person's ability to function in their usual role of giving self-care. An impairment of this nature may damage or decrease the client's self-concept. The client may then perceive himself as dependent and become depressed, which may further limit the effort to do for himself. Thus, a cycle begins. The client is unable to do certain things for himself, resulting in a reduced image of self as capable. The client, then, does not try and becomes more functionally impaired or dependent, which in turn, causes an even greater decrease in self-concept.

Self-concept is important to the elderly. Numerous studies have shown that people with a high self-concept are generally happier, more independent, more self-confident, less anxious, and more effective in meeting environmental demands than those with low self-concept. Persons with low self-concept may exhibit loss of confidence, anticipate failure, or experience shame and a sense of failure. Therefore, people with a higher self-concept will be able to function more effectively and will not be as apt to require hospitalization, nursing service, or social service as those with a low self-concept (Ebersole & Hess, 1981).

Clients who are functionally impaired may exhibit different levels of self-concept. Some may have a higher self-concept than others due to the degree of impairment and/or the presence and effectiveness of coping mechanisms. For whatever the reason, the client with the higher self-concept will be functioning more effectively and at a higher level than the client with a lower self-concept. Therefore, the client with a higher self-concept and better level of functioning should require fewer hospitalizations and less nursing and/or social service (Ebersole & Hess, 1981).

If one could determine the relationship between functional impairment and self-concept, one could intervene and break the cycle, or at least minimize the impact of the interaction between functional impairment and self-concept. It is within the role of the Geriatric Nurse Clinician (GNC) to be able to identify potential effects on the self-concept of clients who are functionally impaired and intervene appropriately in order to minimize the impact of functional impairment on self-concept in the elderly.

The researcher became interested in the relationship between functional impairment and self-concept because of personal observation of the functional impairment-dependency-depression-lowered self-concept cycle in his experiences in home health care. The researcher believes this relationship is one that is frequently neglected and warrants greater attention from health care providers and care givers.

The number of clients who have functional impairment severe enough to require assistance from agencies such as home health is significant. Attempts to control health care costs, i.e., Diagnosis Related Groupings (DRGS), have been made that are resulting in a greater emphasis on caring for clients in the home. There are approximately 430 clients that receive nursing service from home health agencies in Lee County. The figure state wide would be approximately 35,000. These figures will likely increase with time as more emphasis is placed on care of clients at home (J. Haggerty, personal communication, February 1, 1985).

If nursing could increase the functional ability of the elderly by intervening in the functional ability self-concept cycle, one could improve the quality of life for the elderly as well as decrease the nursing load. To be able to do this, one must know the relationship between functional impairment and self-concept. This study sought to determine the relationship between functional impairment and self-concept in the elderly. The research question was: What is the relationship between functional impairment and self-concept in the elderly with chronic illness?

Chapter II

Theoretical Basis for Study

The theory of nursing proposed by King (1981) will be utilized as the theoretical framework for examining the relationship of functional impairment and self-concept in the elderly. King does not believe in the existence of a health illness continuum. According to King, illness is a functional state of health for each individual. A person may be able to function even though he may have some type of chronic illness. The level of functioning will depend upon the extent of impairment produced by the illness. Thus, the ability of one to function in his usual roles is what King refers to as health. An evaluation of an individual's health state must include an examination of all his roles. The level of health is then determined not by the presence of illness but by one's ability to fulfill such roles as provider, spouse, or friend.

The effects of chronic illnesses, such as hypertension, have the potential to greatly impair functioning in usual roles. The effects of chronic illnesses usually take years to develop. The elderly with a high incidence of chronic illnesses are more likely to have an impaired level of functioning. A level of functioning highly valued by the

elderly is independence, particularly in Activities of Daily Living (ADL). Thus, an elderly individual's ability to fulfill such roles as self-care agent, provider, spouse, or friend will determine his level of health.

However, there is often a disparity between the individual's ability to function in one's role and the actual functioning in that role. A key factor in this disparity is the way in which one perceives himself. According to King, perception is "each individual's representation or image of reality" (King, 1981, p. 20). It is through perception that an individual comes to know self and establishes a self-concept. It is the combination self-concept and ability to function which determines how well one fulfills his role, and thus determines his level of health.

Individuals with chronic illness often perceive themselves as sick and unable to fulfill their usual roles such as self-care agent, provider, spouse, or friend. Although the impairment due to illness may not be great, the perception of self as impaired may lead to an increase in impairment. Therefore, this impairment may be due to concept of self rather than the disease itself.

In King's (1981) theory, nursing is a process by which clients are assisted to function in their usual role. Therefore, the GNC needs to assess the level of impairment the elderly has as well as the elderly's concept of self.

After the assessment of these two areas, the GNC should be able to identify the problem as one of actual impairment and/or self-concept. Having identified the problem, the GNC can then develop a specific plan of care with appropriate nursing interventions to assist the elderly to function in their roles at the highest level.

Health, according to King (1981), is determined by one's ability to function in his usual role. This functioning is influenced by one's perception of self. Therefore, determining factors of health include one's ability to perform ADL and one's self-concept. This study investigates the relationship of the ability of elderly clients who have a chronic illness to function in their usual role and their self-concept.

Chapter III

Theoretical Null Hypothesis

Theoretical Hypothesis

There is no significant correlation between functional impairment and self-concept of clients with chronic illnesses who receive nursing care.

Definitions

1. Significant correlation: a relationship between scores of two different tools which occurs only 5 times out of 100 by chance as determined by a statistical test. Operationally defined, a relationship between scores on the Functional Assessment Form and the Tennessee Self-Concept Scale which occurs only 5 times out of 100 by chance using the Pearson's Product Moment Correlation Coefficient.

2. Functional impairment: the inability, due to a health problem, to fulfill one's usual personal or social role. Operationally defined, functional impairment is the inability to perform ADL as the result of a specific physical condition such as paralysis, breathlessness, or weakness, as measured by the Functional Assessment Form.

3. Self-concept: an individual's representation or image he has for himself. Operationally defined,

self-concept is the perception one has for himself as measured by the Tennessee Self-Concept Scale.

4. Client: a person who utilizes the services of the professional health care team. Operationally defined, client is a person 65 years of age, or older, who uses the services of registered nurses from a home health agency.

5. Chronic illness: a diagnosis of two years, or more, that is of slow progression and long continuance. Operationally defined, this includes, but is not limited to, conditions such as chronic obstructive pulmonary disease, cerebrovascular accident, arthritis, diabetes, or cancer.

6. Nursing care: care provided to the client by nursing personnel. Operationally defined, nursing care is care provided by home health registered nurses.

Operational Hypothesis

Using the Pearson's Product Moment Correlation Coefficient, there is no relationship at the .05 significance level between scores on the Functional Assessment Form and the Tennessee Self-Concept Scale of clients 65 years of age or older with a chronic illness receiving nursing service from a home health agency.

Chapter IV

Review of Literature

There exists a limited amount of research describing the relationship of functional impairment and self-concept in the elderly who have a chronic illness, as well as limited research identifying factors important in self-concept. Since morale and life satisfaction are logically connected to self-concept, studies which explored the relationship of these concepts to chronic illness were reviewed. Since functional impairment in the elderly often results from chronic conditions, studies determining the degree of impairment that resulted from chronic conditions were reviewed. This research was also limited because studies of chronically ill persons are difficult to design and manage (Sexton, 1983).

Hanson (1982) conducted a study on the effects of chronic lung disease on life in general and on sexuality and the perceptions of adult patients. In this descriptive study, the impact of lung disease on life in general, as perceived by the victim of the disease, was identified using a tool consisting of 40 questions pertaining to life in general, aspects of sexuality, and treatment of symptoms.

The items were grouped into 11 clusters, each cluster reflecting one area of life which might be affected by lung disease. The participants, 128 adults with chronic lung disease ranging in age from young adults to those in their eighth decade, overwhelmingly reported that the effects of lung disease were very important to them. The participants identified this importance in all of the 11 areas under study. One area under study was the person's need to depend on others. In this area, 67% perceived the effects and impairment of lung disease as negative while 33% were non-critical of the effects. The negative effect implies an increased dependency on others for needs to be met.

The impact of chronic airflow obstruction on ADL was investigated by Chalmers (1984). In her study, 30 adults with mild, moderate, and severe levels of airflow obstruction were interviewed in their homes, using an interview guide which had been specifically designed for this study. The interviews were taped, fully transcribed, and then analyzed for patterns of functioning. Chalmers found that the presence of chronic respiratory disease affected all the respondents in some way, regardless of the severity of their symptoms. Of primary concern was their ability to maintain a desired role within their family and society. While each person's idea of what his level of involvement was differed, everyone valued the ability to fulfill personal role expectations such as provider, spouse,

and friend. Respondents who had difficulty or were not able to fulfill their role expectations expressed feelings of powerlessness, frustration, and inadequacy (Chalmers, 1984).

A study by Ryden (1983) examined the relationship of five different variables and morale in elderly clients in nursing homes. One of these variables was functional dependency and its relation to morale. The sample was drawn from residents of four nursing homes, which were randomly chosen from a population of urban, proprietary nursing homes. The sample size was 113; 59 of which were intermediate care; and 54 of which were skilled care. Differences in functional dependency between residents on skilled and intermediate units were more apparent. Six times as many residents on skilled care were found in the three most dependent categories when compared with residents on intermediate care. However, perceived control was the only variable that had a significant direct effect on the morale of the residents on skilled care. In contrast, functional dependency had a significant direct effect on the morale of residents on intermediate care (Ryden, 1983). The finding that functional dependency had the most powerful effect on the morale of residents on intermediate care while it had only a negligible effect on the morale of residents on skilled care is very interesting. An implication of these findings is the need to help residents deal with the feelings accompanying increased dependency.

Stoller and Earl (1983) state that a consistent finding of recent research in social gerontology has been the importance of the family as a source of support for older citizens. Family members play a vital role in assisting older persons in carrying out ADL and provide support in times of illness. In addition to ADL, families also assist with nonpersonal needs. Researchers Pihlblad, Hessler, and Freshley (1975) and Powers and Bultena (1974) (cited in Stoller & Earl, 1983) have reported that their institutionalized elderly respondents received regular help from family members in meeting their nonpersonal needs, such as with housework, shopping, or transportation (Stoller & Earl, 1983). However, willingness to assist older persons cannot be equated with competence to meet the needs of the chronically ill or functionally impaired older person over a long period of time.

It has been pointed out that today's families do not have the structural, organizational, and economic resources to provide such care. The informal helping network is apparently unable to cope with impaired and disabled individuals on a long-term continuing basis (Stoller & Earl, 1983).

In their study, Stoller and Earl (1983) explored sources of support for older persons of varying levels of functional capacity. Data were gathered through interviews with a probability sample of 753 noninstitutionalized elderly in Northeastern New York State. A major part of

the interview schedule was the Comprehensive Assessment, Referral, and Evaluation (CARE) instrument. This tool served as a guide to cover psychiatric, medical, nutritional, economic, and social problems of the older person. From this study, the analysis suggest that spouses are the primary source of help for married elders with impaired capacity, and adult daughters are the major helpers when a spouse is not present or when the level of support provided by the spouse is not sufficient. Helping networks increase in both size and scope as functional capacity declines. This implies the involvement of agencies such as home health.

In summary, studies reviewed mentioned the areas of dependency in chronic illness, perceived control (self-concept), and maintenance of role (ADL). Based on the nursing theory of King (1981), health is the ability of a person to fulfill his/her usual role. The extent to which a person is fulfilling his/her usual role determines the level of health of that person. Here, dependency occurring as a result of functional impairment may alter one's level of health. When this occurs, self-concept of that person is often adversely affected. Hopefully, as further study and research are done, the GNC will be able to identify and implement specific nursing actions that will improve self-concept and the quality of life of the elderly who are functionally impaired.

Chapter V

Research Design and Methodology

Research Approach

The researcher intended to describe and compare the relationship of functional impairment and self-concept of elderly clients with chronic illness. To accomplish this, the researcher used the descriptive research design. Descriptive research, according to Polit and Hungler (1983), seeks to "describe phenomena rather than explain them" (p. 18). This descriptive study on the relationship of functional impairment and self-concept in the elderly could have implications for geriatric nursing practice.

Variables

The dependent variables were functional impairment and self-concept, as measured by the Functional Assessment Form (see Appendix A) and the Tennessee Self-Concept Scale (see Appendix B), respectively. Controlled variables included mental state, age, and ability to hear, see, and read. The intervening variables included an altered self-concept for reasons other than functional impairment (i.e., loss of spouse, history of depression) and cultural background.

Setting, Population, and Sample

The setting for this study was a rural eight-county area of Northeast Mississippi. The counties included Lee, Pontotoc, Prentiss, Itawamba, Monroe, Union, Chickasaw, and Tippah. The population of this eight-county area, according to the 1980 census, is 217,280 (Official and Statistical Register, 1984-1988).

The population consisted of clients over 65 years of age who were receiving home health nursing service from the North Mississippi Medical Center Home Health Agency. This agency serves this eight-county area with a case load of approximately 275 clients. The agency employs 15 registered nurses, and other services provided by this agency include home health aid, physical therapy, speech therapy, and respiratory therapy. The case load exhibits a broad range of diagnoses, represents various socioeconomic levels, and has an age range from 4 months to 90 years. Of these 275 clients, 37% are male, 63% female, 79% white, and 21% black. Approximately 85% of these clients are over the age of 65 with an average age of 72 (J. Haggerty, personal communication, February 1, 1985).

The sample consisted of 15 clients from the home health agency. They were at least 65 years of age, had a chronic illness, and agreed to participate in the study. This type sampling was chosen because of the cooperation and availability of the agency, availability of clients for use as subjects, and the time factor.

Data Gathering Process

The researcher contacted the Director of North Mississippi Medical Center Home Health Agency and explained the purpose and methodology of the study. An Agency Agreement (see Appendix C) was completed and signed by the researcher and director of the agency for permission to use the facility for selecting the sample for the study. The researcher determined the eligibility of clients to participate in the study by home health audit review, chart review, and verbal questioning of the nursing supervisor. Criteria for selection included age 65 or over, receiving home care by a registered nurse, and a chronic illness for at least two years. After identifying potential subjects, the researcher telephoned to make an appointment and arrange to visit the subjects. The researcher explained the study to the subjects and asked them three questions, specifically their name, the month of the year, and their date of birth, in order to determine their mental status. All subjects that were contacted responded accurately to these questions and agreed to participate in the study. The subjects then signed an Informed Consent (see Appendix D).

A short demographic data sheet (see Appendix E) consisting of seven questions was completed by the researcher. Following this, the Functional Assessment Form was administered by the researcher. After completing this form, the Tennessee Self-Concept Scale was completed by the researcher. The subjects were not able to complete

the Tennessee Self-Concept Scale because of their decreased visual acuity, lack of fine motor coordination, and the complexity of using the answer sheet with the textbook. Therefore, the researcher verbally administered all the tools and recorded the information for the subjects, and one hour was allowed for completing the tools. The researcher remained with the subjects until he completed all three questionnaires. After the questionnaires were completed, the researcher expressed his thanks to the subjects for their cooperation and participation. All tools were coded with no names appearing on them in order to maintain confidentiality.

Instrumentation

The Functional Assessment Form, designed by the researcher, measured the ability of the elderly to carry out activities of daily living. The tool measured 10 specific activities: namely, mobility, walking, bathing, dressing, toileting, bowel function, bladder function, use of wheelchair, transferring, and eating/feeding. These areas were identified in the literature as Activities of Daily Living (ADL) in which the elderly engage (Ebersole & Hess, 1981; Stoller & Earl, 1983). The tool was also evaluated by a panel of experts, including a director of a home health agency, director of a nursing home, and director of a Geriatric Nurse Clinician program. Thus, the tool possesses face validity. Reliability of the Functional Assessment Form will be established by future research studies.

To arrive at an assessment of functional level, each of the 10 activities identified above were scored from 1 to 4, one indicating ability to perform the activity and 4 indicating total dependency in performing the activity. The scores of each activity were then totaled to arrive at a score indicating the functional level of the elderly. The scores can range from 10 indicating independence to a score of 40 indicating dependency.

The Tennessee Self-Concept Scale, developed by Fitts (1970), measures the way one feels about oneself. It consists of 100 questions, 90 assessing self-concept and 10 assessing self-criticism. The items to measure these two areas were selected by seven clinical psychologists who derived them from surveys of the literature on the self-concept and from analyses of patient self-reports.

The Tennessee Self-Concept Scale has been widely used in research on all age groups, including the elderly. Reliability, established by test-retest, is in the high .80s and is large enough to warrant confidence in individual difference measurement. The various content areas of the Tennessee Self-Concept Scale are well conceived and the score reveals a vast amount of reliable information from the 100 test items and was a suitable tool for this research.

To score the Tennessee Self-Concept Scale, each item or question is ranked on a scale of 1 to 5 with one being completely false and 5 being completely true. A major Total Positive score, reflecting the overall level of self-esteem,

was derived. In addition, nine subscores were derived that measured the areas of identity, self-satisfaction, behavior, physical self, moral-ethical self, personal self, family self, social self, and self-criticism. A high percentile rank according to the Total Positive score would indicate a positive view of oneself, whereas a lower percentile rank would indicate a poor view of oneself.

Statistical Analysis

The Pearson Product Moment Correlation Coefficient was used to determine the relationship between self-concept and functional ability. The correlation coefficient is the statistical procedure used to determine the "magnitude and direction of a relationship between two variables" (Polit & Hungler, 1983, p. 521).

Assumptions

1. Self-concept can be measured.
2. Functional impairment can be measured.
3. All respondents are answering honestly.

Limitations

1. Limiting the study to Northeast Mississippi prohibits generalization to other geographic areas.
2. Limiting to age 65 or older prohibits generalization to younger groups.
3. Limiting the study to elderly with chronic illness prohibits generalization to elderly without chronic illness.

Chapter VI

Analysis of Data

The purpose of this study was to determine the relationship between functional impairment and self-concept in elderly clients with chronic illness. Data were collected from subjects by means of a demographic questionnaire, a researcher-designed tool called Functional Assessment Form, and the Tennessee Self-Concept Scale.

A total of 15 subjects were used in the study. The majority of these subjects were white (12), female (9), and within the age range of 65 to 75 (11) years of age with an average age of 73.3. There was almost an equal number of those who were married (6) and those widowed (7), while one was single and one was divorced. Most of the subjects had had a chronic illness over five years. Five were living alone and the remainder lived with their spouse and/or other family members. The majority of the subjects were within the income range of $5,000-$10,000 per year. The specifics of these data may be found in Table 1.

Table 1

Demographic Data Including Age, Race, Sex, Marital Status, Length of Chronic Illness, and Number in Household

Subject	Age	Race	Sex	Marital Status	Length of Chronic Illness in Years	Income in Thousands	Number in Household
S_1	69	W	M	M	> 5	5-10	2
S_2	74	W	M	M	1-2	10-15	2
S_3	65	W	M	M	3-5	5-10	2
S_4	76	W	F	M	> 5	3-5	2
S_5	65	W	M	D	> 5	5-10	3
S_6	92	W	F	W	> 5	5-10	1
S_7	84	W	F	W	> 5	5-10	3
S_8	73	B	F	M	3-5	5-10	2
S_9	72	B	F	W	> 5	5-10	1
S_{10}	66	W	F	W	> 5	> 15	1
S_{11}	74	W	F	W	3-5	> 15	1
S_{12}	89	W	F	W	5-10	5-10	1
S_{13}	65	W	M	M	> 5	5-10	2
S_{14}	68	W	M	S	3-5	3-5	7
S_{15}	68	B	F	W	> 5	5-10	2

There was a wide variety of reported chronic illnesses and some subjects who reported more than one chronic illness. The diseases reported were arteriosclerotic heart disease (5), diabetes (4), cerebrovascular accident (4), arthritis (3), chronic obstructive pulmonary disease (2), congestive heart failure (2), amputees (2), high blood pressure (2), psoriasis (1), multiple sclerosis (1), and leukemia (1).

The subjects' scores on the Functional Assessment Form ranged from 10 to 34 with a mean of 20.40. The Total Positive scores on the Tennessee Self-Concept Scale ranged from 281 to 404 with a mean of 360.33. On the Tennessee Self-Concept Scale, the Self-Criticism scores ranged from 20 to 45 with a mean of 28.7. The raw scores from both tools can be found in Table 2.

Hypothesis

The researcher hypothesized that when the subjects' scores on the Functional Assessment Form and the Tennessee Self-Concept Scale were correlated, there would be no significant correlation. To test this hypothesis, data were subjected to the Pearson Product Moment Correlation Coefficient at the .05 level of significance. Comparisons were made using the functional assessment scores and the Total Positive scores in addition to the eight other subscores derived from the Tennessee Self-Concept Scale.

Table 2

Functional Assessment and Tennessee Self-Concept Scores

Subject	Functional Assessment Score	Self-Criticism Score	Total P	R_1	R_2	R_3	CA	CB	CC	CD	CE
S_1	12	33	354	118	124	112	61	75	75	81	62
S_2	10	35	376	144	125	107	69	85	66	81	75
S_3	13	32	396	132	128	136	80	80	76	81	79
S_4	19	21	404	132	141	131	67	88	82	82	85
S_5	11	31	340	121	103	116	51	75	70	78	66
S_6	18	26	341	111	130	100	62	77	70	70	62
S_7	34	21	370	125	128	117	64	86	71	77	72
S_8	26	29	305	108	107	90	44	70	62	69	60
S_9	28	20	360	127	115	118	65	85	74	74	62
S_{10}	20	45	369	135	116	118	59	82	68	81	79
S_{11}	11	26	403	135	143	125	75	82	83	84	79
S_{12}	21	30	368	130	130	108	52	89	70	80	77
S_{13}	32	37	342	126	100	116	55	73	78	66	70
S_{14}	26	30	281	89	99	93	63	72	55	49	42
S_{15}	25	25	396	134	137	125	69	90	79	81	77

These comparisons revealed significance with one subscore of the Tennessee Self-Concept Scale, Column D, or Family Self, with a value of -0.4982. The other values were not significant, but the Total Positive score and the subscores for Identity, Self-Satisfaction, Physical Self, and Social Self were in the range of -0.3246 to -0.2576. The values for the remainder of the subscores ranged from -0.2064 to -0.0033. Because there was significance with one of the subscores, the researcher rejected the null hypothesis. These data can be found in Table 3.

Table 3

Correlation Analysis of Tennessee Self-Concept Scores to Functional Assessment Scores

Measure	Correlation Coefficient	Significance
Total Positive	-0.3262	.1170
Row 1	-0.2987	.1396
Row 2	-0.3246	.1183
Row 3	-0.2064	.2334
Column A	-0.3098	.1302
Column B	-0.0033	.5000
Column C	-0.1604	.2869
Column D	-0.4982*	.0282
Column E	-0.2576	.1844

*$p \leq .05$.

Chapter VII

Summary, Conclusions, Implications, and Recommendations

Summary

This was a descriptive study designed to determine the relationship of functional impairment and self-concept of elderly clients with chronic illness. The null hypothesis stated that when the clients' scores on the Functional Assessment Form and Tennessee Self-Concept Scale were compared, there would be no significant correlation at the .05 significance level.

Data were collected from 15 subjects who were 65 years of age or over, had a chronic illness, and were receiving the services of a home health agency. All subjects were administered the Functional Assessment Form and the Tennessee Self-Concept Scale. These scores were then compared utilizing the Pearson Product Moment Correlation Coefficient at the .05 level of significance.

The results demonstrated significance between the subject's functional assessment score and one subscore, Column D, of the Tennessee Self-Concept Scale. Thus, the researcher rejected the null hypothesis.

Conclusions and Implications

The data from this study indicate that there is a correlation between functional impairment and "Family Self" and no correlation between functional impairment and the Total Positive scale or other subscores of the Tennessee Self-Concept Scale. The "Family Self" score reflects one's feelings of adequacy, worth, and value as a family member. It refers to the individual's perception of self in reference to his closest and most immediate circle of associates.

These findings support the research findings of Hanson (1982), Chalmers (1984), and Stoller and Earl (1983). Their findings correlate with the "Family Self" subscore that was significant in this research study.

In their studies, the effects of chronic disease on clients were identified. One of the major effects identified dealt with increased dependency on others for need to be met. Clients value the ability to fulfill personal role expectations such as provider, spouse, and friend. Because of the impact a chronic illness may have on clients, they are frequently unable to fulfill their role expectations. As a result, spouses and/or family members play a vital role in assisting older persons in carrying out ADL. Thus, their feelings of adequacy, worth, and value as a family member may be diminished.

These findings suggest intervention by the Geriatric Nurse Clinician (GNC) in the area of enhancing the client's self-worth and feelings of adequacy as a family member. The GNC could work with the clients and assist them to improve their self-perception by identifying positive aspects of their lives and accomplishments they have achieved. Also, the GNC could involve other family members or significant others to identify ways to maximize the client's potential for increasing their role performance. Perhaps, identifying simple tasks these clients could perform and assigning them these type responsibilities would serve to improve this need in clients who have functional impairment.

While the Total Positive and other subscores were not significant, two contributing factors were identified. First, the Self-Criticism score on the Tennessee Self-Concept Scale indicates the defensiveness of the subjects. High scores generally indicate a normal, healthy openness to the questions, whereas low scores indicate greater defensiveness and suggest that the positive scores may be artificial. The Self-Criticism scores of the subjects were low, indicating defenses, and this could very well be related to the fact that the researcher verbally administered this tool. Therefore, the Total Positive score and the subscores on Identity, Self-Satisfaction, Physical Self, and Social Self that were not significant might have been found significant if the tool had been

self-administered. Additionally, the defensiveness factor could have contributed to the significance level for the subscore on Behavior, Moral-Ethical Self, and Personal Self, but significance with these subscores may not have shown regardless of whether or not the tool was self-administered. Although the subscore on Family Self was the only one significant, the GNC cannot ignore the other subscores. These areas, in addition to Family Self, must be incorporated into the nursing care plan of the geriatric client.

Another contributing factor to finding no significance was the small sample size. A larger sample size might have created a situation where the Total Positive and/or more subscores were significant.

The mean of the functional assessment scores indicated a significant degree of dependency among the subjects. Therefore, one might question whether the degree of functioning ability of subjects living at home with chronic illness would be the same as that of subjects with a chronic illness living in an institution. The same question could be asked about their self-concept. One could also question whether or not its functional impairment, self-concept, or a combination of the two that determines whether or not the client remains at home or is institutionalized.

Recommendations

Based upon the findings of this study, the following recommendations are made:

Research

1. Replication of the study using a larger sample size.

2. Conduction of a similar study using a self-concept tool that does not have to be verbally administered.

3. Conduction of a similar study controlling for chronic illness.

4. Replication of the study using a more even race distribution.

5. Conduct a comparative study using institutionalized and non-institutionalized clients who have a chronic illness.

Nursing

6. Utilize the knowledge of the correlation between functional impairment and perception of self as a family member by geriatric clients.

7. Communicate the significance that role of family member plays, relative to geriatric clients, to health care providers.

Appendix A

Total Points_____
Code Number_____

Functional Assessment Form

Instructions:

Place a check ( ) in the blank beside the statement that best describes your level of functioning. Check only one blank in each section.

I. Mobility Level

_____ 1. Goes outside facility/house.
_____ 2. Moves about inside house/facility.
_____ 3. Confined to bed and chair.
_____ 4. Confined to bed.

II. Walking

_____ 1. Walks without assistance.
_____ 2. Walks with cane or walker.
_____ 3. Walks if accompanied by another person.
_____ 4. Unable to walk.

III. Bathing

_____ 1. Takes bath and/or shower by self.
_____ 2. Bathes in bathroom with assistance.
_____ 3. Bathes in bathroom but requires full assistance.
_____ 4. Has to be bathed in bed.

IV. Dressing

_____ 1. Selects clothes and dresses self.
_____ 2. Dresses self after clothing selected or obtained.
_____ 3. Requires assistance with dressing.
_____ 4. Unable to dress self.

V. Toileting

_____ 1. Uses bathroom during day and night.
_____ 2. Uses bathroom during day, bedpan/urinal at night.
_____ 3. Uses bathroom in day, bedside commode at night.
_____ 4. Does not use bathroom at all, uses bedpan, urinal, or bedside commode.

VI. Bowel Function

_____ 1. Always able to control bowels.
_____ 2. Unable to control bowels 1-2 times a week.
_____ 3. Unable to control bowels more than twice a week.
_____ 4. Has a colostomy.

VII. Bladder Function

_____ 1. Always able to control kidneys.
_____ 2. Unable to control kidneys 1-2 times a week.
_____ 3. Unable to control kidneys more than twice a week.
_____ 4. Has a catheter.

VIII. Wheelchair

_____ 1. Does not require wheelchair--walks.
_____ 2. Uses wheelchair and wheels self.
_____ 3. Is wheeled by others.
_____ 4. Unable to use wheelchair--confined to bed.

IX. Transferring

_____ 1. Can move from bed to chair without help.
_____ 2. Requires assistance moving from bed to chair.
_____ 3. Has to be lifted from bed to chair.
_____ 4. Does not get up--confined to bed.

X. Eating/Feeding

_____ 1. Prepares meals.
_____ 2. Can eat after meal is set up.
_____ 3. Is fed by others.
_____ 4. Has feeding tube.

Tennessee Self-Concept Scale

William H. Fitts, Ph.D.

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INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill in these boxes later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself *to yourself. Do not omit any item.* Read each statement carefully, then select one of the five responses listed below. On your answer sheet, put a *circle* around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an *X* mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked *time started* and record the time. When you are finished, record the time finished in the box on your answer sheet marked *time finished.*

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a *circle* around the response number you have chosen for each statement.

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

You will find these response numbers repeated at the top of each page to help you remember them.

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
1.	I have a healthy body	1
3.	I am an attractive person	3
5.	I consider myself a sloppy person	5
19.	I am a decent sort of person	19
21.	I am an honest person	21
23.	I am a bad person	23
37.	I am a cheerful person	37
39.	I am a calm and easygoing person	39
41.	I am a nobody	41
55.	I have a family that would always help me in any kind of trouble	55
57.	I am a member of a happy family	57
59.	My friends have no confidence in me	59
73.	I am a friendly person	73
75.	I am popular with men	75
77.	I am not interested in what other people do	77
91.	I do not always tell the truth	91
93.	I get angry sometimes	93

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
2.	I like to look nice and neat all the time	2
4.	I am full of aches and pains	4
6.	I am a sick person	6
20.	I am a religious person	20
22.	I am a moral failure	22
24.	I am a morally weak person	24
38.	I have a lot of self-control	38
40.	I am a hateful person	40
42.	I am losing my mind	42
56.	I am an important person to my friends and family	56
58.	I am not loved by my family	58
60.	I feel that my family doesn't trust me	60
74.	I am popular with women	74
76.	I am mad at the whole world	76
78.	I am hard to be friendly with	78
92.	Once in a while I think of things too bad to talk about	92
94.	Sometimes, when I am not feeling well, I am cross	94

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
7.	I am neither too fat nor too thin	7
9.	I like my looks just the way they are	9
11.	I would like to change some parts of my body	11
25.	I am satisfied with my moral behavior	25
27.	I am satisfied with my relationship to God	27
29.	I ought to go to church more	29
43.	I am satisfied to be just what I am	43
45.	I am just as nice as I should be	45
47.	I despise myself	47
61.	I am satisfied with my family relationships	61
63.	I understand my family as well as I should	63
65.	I should trust my family more	65
79.	I am as sociable as I want to be	79
81.	I try to please others, but don't overdo it	81
83.	I am no good at all from a social standpoint	83
95.	I do not like everyone I know	95
97.	Once in a while, I laugh at a dirty joke	97

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
8.	I am neither too tall nor too short	8
10.	I don't feel as well as I should	10
12.	I should have more sex appeal	12
26.	I am as religious as I want to be	26
28.	I wish I could be more trustworthy	28
30.	I shouldn't tell so many lies	30
44.	I am as smart as I want to be	44
46.	I am not the person I would like to be	46
48.	I wish I didn't give up as easily as I do	48
62.	I treat my parents as well as I should (Use past tense if parents are not living)	62
64.	I am too sensitive to things my family says	64
66.	I should love my family more	66
80.	I am satisfied with the way I treat other people	80
82.	I should be more polite to others	82
84.	I ought to get along better with other people	84
96.	I gossip a little at times	96
98.	At times I feel like swearing	98

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
13.	I take good care of myself physically	13
15.	I try to be careful about my appearance	15
17.	I often act like I am "all thumbs"	17
31.	I am true to my religion in my everyday life	31
33.	I try to change when I know I'm doing things that are wrong	33
35.	I sometimes do very bad things	35
49.	I can always take care of myself in any situation	49
51.	I take the blame for things without getting mad	51
53.	I do things without thinking about them first	53
67.	I try to play fair with my friends and family	67
69.	I take a real interest in my family	69
71.	I give in to my parents (Use past tense if parents are not living)	71
85.	I try to understand the other fellow's point of view	85
87.	I get along well with other people	87
89.	I do not forgive others easily	89
99.	I would rather win than lose in a game	99

Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
1	2	3	4	5

		Item No.
14.	I feel good most of the time	14
16.	I do poorly in sports and games	16
18.	I am a poor sleeper	18
32.	I do what is right most of the time	32
34.	I sometimes use unfair means to get ahead	34
36.	I have trouble doing the things that are right	36
50.	I solve my problems quite easily	50
52.	I change my mind a lot	52
54.	I try to run away from my problems	54
68.	I do my share of work at home	68
70.	I quarrel with my family	70
72.	I do not act like my family thinks I should	72
86.	I see good points in all the people I meet	86
88.	I do not feel at ease with other people	88
90.	I find it hard to talk with strangers	90
100.	Once in a while I put off until tomorrow what I ought to do today	100

Appendix C

Agency Agreement for

Research Study

Descriptive Study: The Relationship Between Functional Impairment and Self-Concept in the Elderly With Chronic Illness

Name of Institution or Agency:

_____

Study discussed with and explained to:

_____
Name and Title

Involvement in Study:

_____ Cooperation: Consent for subjects to be used in study.

Comments:

_____ _____
Date Representative's Signature

_____
Investigator's Signature

Appendix D

Code Number____

Informed Consent Form

Descriptive Study: The Relationship Between Functional Impairment and Self-Concept in the Elderly With Chronic Illness

My name is Larry Loden. I am a registered nurse and graduate student at Mississippi University for Women. I am conducting a research study concerned with how chronic illness is related to a person's self-concept. I would like for you to complete three questionnaires. This should take about one hour. No harmful effects have been identified and I will be glad to answer any questions you might have. You may withdraw your consent to participate at any time. Your participation may help improve the care of the elderly who have a chronic illness. All information will be kept confidential, and no names appear on the form.

I understand the explanation given to me. I understand that I have the right to withdraw from the study should I so desire.

_____ _____

Date Subject's Signature

_____

Researcher

____ Check if you would like results of this study.

Appendix E

Code Number_____

Demographic Data

Instructions:

Please take time to answer these questions. These are general questions concerning you and your health history. This information will be confidential. Check the appropriate blank.

1. How many people live in your household?
   1_____ 2_____ More than 2_____

2. What is the relationship of them to you?
   Spouse_____ Brother_____ Sister_____
   Son_____ Daughter_____ Other_____

3. What is your age?
   65-70_____ 70-75_____ 75-80_____ Over 80_____

4. What is your sex?
   Male_____ Female_____

5. What is your race?
   Black_____ White_____ Other_____

6. How long have you had a chronic illness?
   1-2 years_____ 3-5 years_____ Over 5 years_____

7. What is your income?
   $3,000-$5,000_____ $5,000-$10,000_____
   $10,000-$15,000_____ Over $15,000_____

References

Chalmers, K. I. (1984). A closer look at how people cope with chronic airflow obstruction. Canadian Nurse, 80(2), 35-38.

Ebersole, P., & Hess, P. (1981). Toward healthy aging: Human needs and nursing response (pp. 18-19, 61, 428-431). St. Louis, MO: C. V. Mosby.

Fitts, W. (1970). Tennessee self-concept scale. Nashville, TN: Counselor Recordings and Tests.

Hanson, E. (1982). Effects of chronic lung disease on life in general and on sexuality: Perceptions of adult patients. Heart & Lung, 11(5), 435-441.

King, I. M. (1981). A theory for nursing (p. 20). New York: John Wiley and Sons.

Official and Statistical Register, State of Mississippi, 1984-1988. (1985, January). Jackson, MS: Dick Molphus, Secretary of State.

Parent, C. J., & Whall, A. L. (1984). Are physical activity, self-esteem, and depression related? Journal of Gerontological Nursing, 10(9), 8-11.

Polit, D., & Hungler, B. (1983). Nursing research: Principles and methods (p. 18). Philadelphia, PA: J. B. Lippincott.

Ryden, M. B. (1984). Morale and perceived control in institutionalized elderly. Nursing Research, 33(3), 130-136.

Sexton, D. L. (1983). Some methodological issues in chronic illness research. Nursing Research, 32(6), 378-380.

Stoller, E., & Earl, L. (1983). Help with activities of everyday life: Sources of support for the noninstitutionalized elderly. The Gerontologist, 23(1), 64-69.